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plans with no beneficiary rebate, described at § 422.304(a)(2); and

(ii) The amount of the monthly prescription drug payment described in § 423.315 (if any).

(3) In addition, CMS pays through the original Medicare program (subject to the usual rules of payment)—

(i) The hospice program for hospice care furnished to the Medicare enrollee; and

(ii) The MA organization, provider, or supplier for other Medicare-covered services to the enrollee.

[70 FR 4729, Jan. 28, 2005, as amended at 70 FR 52027, Sept. 1, 2005]

§ 422.322 Source of payment and effect of MA plan election on payment.

(a) *Source of payments.* (1) Payments under this subpart for original fee-for-service benefits to MA organizations or MA MSAs are made from the Federal Hospital Insurance Trust Fund or the Supplementary Medical Insurance Trust Fund. CMS determines the proportions to reflect the relative weight that benefits under Part A, and benefits under Part B represents of the actuarial value of the total benefits under title XVIII of the Act.

(2) Payments to MA-PD organizations for statutory drug benefits provided under this title are made from the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.

(3) Payments under subpart C of part 495 of this chapter for meaningful use of certified EHR technology are made from the Federal Hospital Insurance Trust Fund or the Supplementary Medical Insurance Trust Fund. In applying section 1848(o) of the Act under sections 1853(l) and 1886(n)(2) of the Act under section 1853(m) of the Act, CMS determines the amount to the extent feasible and practical to be similar to the estimated amount in the aggregate that would be payable for services furnished by professionals and hospitals under Parts B and A, respectively, under title XVIII of the Act.

(b) *Payments to the MA organization.* Subject to §§ 412.105(g), 413.86(d), and 495.204 of this chapter and §§ 422.109, 422.316, and 422.320, CMS' payments under a contract with an MA organization (described in § 422.304) with respect

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to an individual electing an MA plan offered by the organization are instead of the amounts which (in the absence of the contract) would otherwise be payable under original Medicare for items and services furnished to the individual.

(c) *Only the MA organization entitled to payment.* Subject to §§ 422.314, 422.316, 422.318, 422.320, and 422.520 and sections 1886(d)(11) and 1886(h)(3)(D) of the Act, only the MA organization is entitled to receive payment from CMS under title XVIII of the Act for items and services furnished to the individual.

[70 FR 4729, Jan. 28, 2005, as amended at 70 FR 52027, Sept. 1, 2005; 75 FR 44654, July 28, 2010]

§ 422.324 Payments to MA organizations for graduate medical education costs.

(a) MA organizations may receive direct graduate medical education payments for the time that residents spend in non-hospital provider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs.

(b) MA organizations may receive direct graduate medical education payments if all of the following conditions are met:

(1) The resident spends his or her time assigned to patient care activities.

(2) The MA organization incurs "all or substantially all" of the costs for the training program in the non-hospital setting as defined in § 413.86(b) of this chapter.

(3) There is a written agreement between the MA organization and the non-hospital site that indicates the MA organization will incur the costs of the resident's salary and fringe benefits and provide reasonable compensation to the non-hospital site for teaching activities.

(c) An MA organization's allowable direct graduate medical education costs, subject to the redistribution and community support principles specified in § 413.85(c) of this chapter, consist of—

(1) Residents' salaries and fringe benefits (including travel and lodging where applicable); and

(2) Reasonable compensation to the non-hospital site for teaching activities related to the training of medical residents.

(d) The direct graduate medical education payment is equal to the product of—

(1) The lower of—

(i) The MA organization's allowable costs per resident as defined in paragraph (c) of this section; or

(ii) The national average per resident amount; and

(2) Medicare's share, which is equal to the ratio of the number of Medicare beneficiaries enrolled to the total number of individuals enrolled in the MA organization.

(e) Direct graduate medical education payments made to MA organizations under this section are made from the Federal Supplementary Medical Insurance Trust Fund.

Subpart H—Provider-Sponsored Organizations

EDITORIAL NOTE: Nomenclature changes to subpart H appear at 63 FR 35098, 35099, June 26, 1998.

§ 422.350 Basis, scope, and definitions.

(a) *Basis and scope.* This subpart is based on sections 1851 and 1855 of the Act which, in part,—

(1) Authorize provider sponsored organizations, (PSOs), to contract as a MA plan;

(2) Require that a PSO meet certain qualifying requirements; and

(3) Provide for waiver of State licensure for PSOs under specified conditions.

(b) *Definitions.* As used in this subpart (unless otherwise specified)—

Capitation payment means a fixed per enrollee per month amount paid for contracted services without regard to the type, cost, or frequency of services furnished.

Cash equivalent means those assets excluding accounts receivable that can be exchanged on an equivalent basis as cash, or converted into cash within 90 days from their presentation for exchange.

Control means that an individual, group of individuals, or entity has the power, directly or indirectly, to direct

or influence significantly the actions or policies of an organization or institution.

Current ratio means total current assets divided by total current liabilities.

Deferred acquisition costs are those costs incurred in starting or purchasing a business. These costs are capitalized as intangible assets and carried on the balance sheet as deferred charges since they benefit the business for periods after the period in which the costs were incurred.

Engaged in the delivery of health care services means—

(1) For an individual, that the individual directly furnishes health care services, or

(2) For an entity, that the entity is organized and operated primarily for the purpose of furnishing health care services directly or through its provider members or entities.

Generally accepted accounting principles (GAAP) means broad rules adopted by the accounting profession as guides in measuring, recording, and reporting the financial affairs and activities of a business to its owners, creditors and other interested parties.

Guarantor means an entity that—

(1) Has been approved by CMS as meeting the requirements to be a guarantor; and

(2) Obligates its resources to a PSO to enable the PSO to meet the solvency requirements required to contract with CMS as an MA organization.

Health care delivery assets (HCDAs) means any tangible assets that are part of a PSO's operation, including hospitals and other medical facilities and their ancillary equipment, and such property as may be reasonably required for the PSO's principal office or for such other purposes as the PSO may need for transacting its business.

Insolvency means a condition in which the liabilities of the debtor exceed the fair valuation of its assets.

Net worth means the excess of total assets over total liabilities, excluding fully subordinated debt or subordinated liabilities.

Provider-sponsored organization (PSO) means a public or private entity that—

(1) Is established or organized, and operated, by a provider or group of affiliated providers;